Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125059	A. BUILDING: _____ B. WING _____ 2015 MAR 18 P 3:52	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOLO CHINESE HOME	2459 10TH AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	11-94.1 Initial Comments A state relicensure survey was conducted at the facility from 1/26 - 1/29/15. At the time of entrance, the resident census was 42.	4 000		
4 123	11-94.1-27(12) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (12)The right to be fully informed in advance about care and treatment and of any changes in that care and treatment and the right to participate in planning care and treatment, unless adjudged incompetent or incapacitated; This Statute is not met as evidenced by: Based on record review and interview with staff members, the facility failed to revise care plans for 1 (Resident #67) of 14 sampled resident of the 26 residents reviewed. Findings include: Cross Reference to 4 136. Resident #67 had three falls from 11/12/14 through 1/25/15. The resident's care plan was not revised based on the resident's abilities and choice. Review of the comprehensive Resident Assessment Instrument with assessment reference date of 9/10/14 notes the resident scored a 3 (severe impairment) when the Brief	4 123	4 123-11-94.1-27 (12) Resident rights and facility practices 1. For resident #67 the resident's care plan was reviewed and revised by the SW, and Nurses based on the resident's abilities and choice on 02/02/15. The intervention to remind the resident to use the call light was deleted due to his severe cognitive impairment; included was staff clarification to stand right outside the bathroom door while resident was using the toilet. 2. On 02/02/14-02/13/15 all resident care plans were audited, reviewed and revised by the SW and Nurses to ensure that it was based on the resident's abilities (cognition and functional abilities) and choice (respect for privacy). 3. All Licensed Nurses, SW and CNAs (current, new annually) were in-serviced on the requirements that care plans must be based on the resident's abilities (cognition and functional abilities) and choice on 2/2/15-2/13/15. All other staff (Dietitian, Food Service Manager) was in-serviced on 02/10/15. 4. The DON/designee will audit each month that care plans are based on the resident's abilities (cognition and functional abilities)	02/02/15 02/13/15 02/13/15 02/16/15

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Admn. 03/06/15

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4 123	Continued From page 1 Interview for Mental Status was administered. In Section F. Preferences for Customary Routine and Activities, how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath, the response was very important. The intervention to remind resident to use the call light was not appropriate for a resident with a severe cognitive impairment. Interview with the DON and MDS Coordinator confirmed based on the resident's cognitive ability (short term memory loss) the resident is unable to benefit from training or education to use the call light. The facility also revised the resident's care plan to include not leaving the resident alone in the bathroom. However, the resident doesn't want staff members in the bathroom with him, the staff member left him and the resident fell. The care plan was not revised to address how staff members should monitor the resident in the bathroom based on the resident's choice while continuing to ensure his safety. The facility failed to revise care plans for fall prevention for Resident #67 with history of falls based on a root cause analysis and an assessment of the resident's cognitive and functional abilities.	4 123	Continued from page 1 and choice (respect for privacy) and the results will be reported to the QA Committee each quarter. Completion date 02/16/15.	
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown;	4 136	4 136-11-94.1-30 Resident care 1. For resident #69 the care plan was reviewed (2/13/15) and did include the following interventions: Resident developed a coccygeal abrasion due to humidity to the coccyx on 9/9/14 with an order of bacitracin ointment and to cover it with non-bordered foam and was on an air mattress. She had a fan and was reminded to turn and reposition	02/13/15

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4 136	Continued From page 2 (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to maintain the skin integrity for 1 Resident, R #69, reviewed for pressure ulcers, and R #67 for fall prevention of the 26 residents reviewed. Findings include: 1) Resident #69 was admitted on 8/18/04 with diagnoses which included: Ileocolic anastomotic leak; septic shock; respiratory failure. Her skin was intact without pressure ulcers. She had an abdominal incision following a recent surgery. A medical record review on the morning of 1/30/15 revealed that wound assessments were conducted weekly. On 9/9/14 there was an abrasion on her sacrum measuring 0.5 cm length x 0.2 cm width x 0.0 cm depth. The abrasion was described as "light pink, mild irritation". The physician was notified on 9/9/14. The wound deteriorated according to the wound assessment dated 9/16/14. It measured 0.5 cm length x 0.5 cm width x 0.1 depth and was described as "light pink, mild irritation". A physician order dated 9/16/14 noted, "Cleanse the coccygeal abrasion with NS, apply Bacitracin ointment, then cover with non-stick dressing every day until healed. Dx: coccygeal abrasion" The wound assessment dated 9/22/14 noted the same measurements	4 136	Continued from page 2. herself. She had an ileostomy and was on Magic Cup. Resident was seen by a physician every Tuesday. On 9/16/14 the dressing order was discontinued and changed to bacitracin ointment and to cover it with non-adherent pad. Resident was using regular underpants during the day. On 9/18/14 was placed on Ensure. On 9/23/14 the dressing order was discontinued and changed to bacitracin ointment and to cover it with bordered foam. On 9/30/14 the skin fractured and the diagnosis was changed to stage 2 pressure ulcer with a new dressing order of clean with normal saline and apply duodenum and to change every 3 days. Care plan was updated on 10/1/14. The resident was continent of bowel and bladder. All the above were care planned and documented. For resident #67 the resident's care plan was reviewed and revised by the DON and ADON based on the resident's abilities and choice on 02/05/15. The intervention to remind the resident to use the call light was deleted due to his severe cognitive impairment; included was staff clarification to stand right outside the bathroom door while resident was using the toilet. Staff is to check/document the proper functioning of the alert alarm at the beginning to each shift; and to ensure that it is turned on and functioning when the resident changes location. Staff was counseled to follow care plans, which is to stand outside the bathroom door while	

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4 136	Continued From page 3 and status was deteriorated. The comments stated the wound bed was whitish without signs or symptoms of infection. The wound assessment dated 9/30/14 noted improved wound status, measured 0.5 cm length x 0.2 cm width x 0.1 depth. A wound physician was notified and the abrasion was diagnosed as a stage 2 pressure ulcer to the coccyx area, with clean reddish wound bed, no signs/symptoms of infection. Resident denied pain during dressing change. The treatment remained the same with duoderm changed daily. A review of the "Assessment of Pressure Sore Potential" tool dated 9/2/14 indicated the resident was low risk for pressure ulcers. R #69's mental status was intact; general health was stable; independently mobile; between 61-70 years old; normal body weight; no pressure sores; never incontinent; no diabetes; and no fracture history. Ate 76-100% meals. Consumed 76-100% fluids. No physical restraints and no psychoactive drugs. A review of R #69's care plan titled, "Potential/actual impaired skin integrity related to 1. Ileostomy, 2. Mid abdominal wound, 3. (9/23/14) Coccyx". Interventions included, "(9/2/14) 0.5 x 0.2 cm excoriation to coccyx, clean with normal saline, apply Bacitracin ointment, cover with non-bordered foam every day. (9/23/14) Cleanse with normal saline, apply Bacitracin ointment, cover with bordered foam every day". No further changes were made to the care plan. The abrasion then became a pressure ulcer. An interview with the Director of Nursing, DON, on the morning of 1/30/15 revealed she was not working when the resident was in the facility. An	4 136	Continued from page 3. resident is using the toilet. 2. On 02/02/15 – 02/13/15 all care plans and wound assessments were audited, reviewed and care plans revised by the DON, ADON and MDS Coordinator to include interventions to prevent pressure ulcers and to promote healing with residents with pressure ulcers. From 02/02/15 staff is to check/document all resident's alert alarms to ensure that it is on and functioning. Resident care plans were revised by the DON and ADON just 1 resident was already care planned to have staff stand right outside the bathroom door while the resident is using the toilet. DON/ ADON will survey weekly x 2 (week of 2/02 and 2/09) weeks then monthly (2/16/15) that alert alarms are functioning and that staff are following care plans. 3. All Licensed Nurses and CNAs (current, new and annually) were in-serviced on the requirements that a resident must receive necessary treatment and services to prevent pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing (resident was wearing own cloth underwear); were in-serviced on the requirements that alert alarms must be checked and documented as on and functioning at the	02/16/15 02/13/15

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4 136	Continued From page 4 Interview with the MDS (Minimum Data Set) Coordinator on the morning of 1/30/15 found the facility assessed the resident and determined R #69 skin breakdown was from moisture. A fan was placed in the room on 9/2/14 when the abrasion was found. The pressure ulcer developed on 9/23/14. No further interventions were initiated. A review of the Admission MDS dated 8/26/14 indicated the following: Bed mobility - supervision and set up; Transfer - supervision and set up; Toilet use - supervision and set up; Personal hygiene - supervision and set up; and Bathing - physical help in part of bathing activity. The 14-day MDS dated 9/1/14 indicated the same functional status. The 30 day MDS dated 9/13/14 indicated a decline in functional status: Bed mobility - limited assistance with 1 person physical assist; Transfer - limited assistance with 1 person physical assist; Toilet use - limited assistance with 1 person physical assist; Personal hygiene - limited assistance with 1 person physical assist; and Bathing - total dependence. The resident was discharged home with the pressure ulcer on 10/3/14. 2) On 1/26/15 at 2:30 P.M. interview was done with the Director of Nursing (DON). The DON reported Resident #67 fell on 1/21/15 when he attempted to get out of bed. He had an abrasion to his forehead, no sutures were needed. Record review done on 1/27/15 at 1:00 P.M. found Resident #67 was admitted to the facility on 9/3/14 with diagnoses including sepsis, pneumonia, and on hospice. Review of the nursing note dated 1/21/15 (11:28 A.M.) notes the	4 136	Continued from page 4. beginning of the shift. Staff must follow care plans and not leave residents unattended while using the toilet on 02/02/15 – 02/13/15. All other staff (Dietitian, Food Service Manager) was in-serviced on 02/10/15. 4. The DON/designee will audit each month that the resident care plans are based on the resident's comprehensive assessment to ensure that a resident receives necessary treatment and services to prevent pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing; alert alarms are being checked that it is on and functioning at the beginning of each shift and that staff are not leaving residents unattended on the toilet and the results will be reported to the QA Committee each quarter. Completion date 02/16/15.	02/16/15

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4 136	Continued From page 5 CNA reported Resident #67 fell to the floor in the bathroom. The nurse notes there was bleeding on the forehead and bilateral arms near the elbow. Resident was sent to emergency department. Upon return a dermabond was applied to the resident's forehead and a CAT scan was done which was negative. Review of the resident's care plan found a plan for potential fall related to history of fall, impaired mobility, BIMS score of 3, hearing impairment, and incontinence. The onset of the care plan was 9/21/14. Interventions included: "Fall Alert" symbol on resident's door as applicable; implement falling star program as applicable; bed locked and in lowest position; ensure floor path clear of clutter and adequate lighting in resident room; ensure call light within reach and answered promptly (encourage resident to await assistance); monitor for signs/symptoms of psychoactive meds; alert alarm on at all times; ensure resident uses eye glasses for ADLs; and resident uses hearing aid for impaired hearing. The resident's care plan was updated on 11/12/14, 11/25/14, 12/2/14 and 12/14/14. The update on 11/12/14 included the following additional interventions: do not leave the resident alone in the bathroom and instruct the resident to use the call button to alert the staff that he is done using the toilet. Review of the nursing notes found the resident fell on 11/25/14, 12/14/14 and 1/21/15. Requested to review the facility's incident reports. The incident reports were provided by the facility and reviewed on 1/28/15 at 9:35 A.M. Resident #67 was found on the bathroom floor on 11/25/14 at 2:40 P.M. A Certified Nurse Aide (CNA) was providing assistance to Resident #67's roommate (transferring to the wheelchair) and heard	4 136		

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4 136	Continued From page 6 something in the bathroom and found the resident on the floor. The resident sustained a laceration to the left eyebrow, abrasion to the nose and skin tear to the left elbow and left upper arm. The CNA reported that the resident's personal alarm did not go off and the alarm was "never turned on". The CNA also reported when he entered to provide care for Resident #67's roommate, Resident #67 was observed to be lying in bed. The resident was interviewed and stated that he did not use the call light and fell in the bathroom when he was attempting to sit on the toilet. The resident was re-oriented about the use of the call light. The facility did not implement the resident's care plan for alert alarm on all times. The facility documents the alarm was not on when resident managed to get out of bed and to the bathroom where he fell. Subsequently Resident #67's care plan was updated (11/25/14) to include the following: offer toilet every 1-2 hours prn, frequent monitor check resident, frequent check bed alarm on and in working condition; routinely check resident throughout the shift; resident does not want clip alarm, it agitates and irritates the resident; floor mattress on each side of the bed; use the walker if resident wants to go the the toilet to stabilize gait and balance. On 12/14/14 at 1:30 A.M. staff heard something fall and found Resident #67 on the bathroom floor. The resident sustained a linear skin tear to the corner of left eye and a left elbow skin tear. Review of the direct care staff (CNA) statement of 12/14/15 at 1:24 A.M. The CNA documents that the resident "keeps on using the toilet and also worrying or looking on invoice papers". The CNA documents the resident did not use his call light, which he "normally" does and was "confused".	4 136		

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4 136	Continued From page 7 The CNA provided another statement dated 12/14/14 at 1:26 A.M. that Resident #67 used the toilet with assistance but did not want the CNA to watch while he was using the toilet so went to stand "by the door by the hallway and normally [resident's name] press his call light but tonight he looks confused". The facility did not implement care plan for fall prevention, do not leave the resident alone in the bathroom and resident fell. The resident's care plan was updated on 12/14/14. Interventions included: continue to monitor for bladder or urinary frequency, resident has history of BPH; toileting schedule program; continuously remind patient to sit down at the edge of the bed for a few minutes before standing up to prevent sudden syncope..." On 1/21/15 Resident #67 fell in his room. He was found at the foot of his bed with laceration to both elbows and forehead. No care plan update was done. Interview with the MDS Coordinator was done on 1/28/15 at 10:21 A.M. The fall of 11/25/14 was reviewed, the MDS Coordinator confirmed that the resident's care plan was not implemented at the time of his fall. The resident's alarm was off when he managed to get out of bed and ambulate to the bathroom. At 10:30 A.M. the DON participated in the interview and concurrent review of the documents provided by the facility. The resident's second fall, dated 12/14/14 was reviewed. The staff members confirmed that the resident's care plan was updated to include intervention of not leaving the resident alone in the bathroom. Reviewed the assigned CNA's written documentation noting she was standing at the hallway door when the resident fell. Inquired whether the resident's care plan was being implemented at the time of the fall. The DON	4 136		

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4 136	Continued From page 8 reported that it is possible that the resident does not want to be watched. Further inquired whether standing at the entrance (hallway door) is where the aide should stand if the resident does not want staff in the bathroom with him. The DON confirmed that the resident's care plan was not being implemented and the care plan was not updated to address the resident's choice of not having staff present while he is using the toilet. Further queried staff members regarding resident's ability to use the call light. The DON reported that the resident has short term memory impairment and will use the call light occasionally. The DON confirmed that the resident is not capable of training to use the call light. The DON reported that during the investigation of the most recent fall, it was found that staff members were not implementing the resident's toileting schedule. The DON has provided re-education to direct care staff members and has been monitoring whether the toilet schedule is being implemented by staff members. The DON further reported the terazosin has been adjusted to address the resident's benign prostatic hypertrophy (BPH). Resident #67 has had three falls (11/25/14, 12/14/14 and 1/21/15). At the time of the resident's falls in November and December, the facility was not implementing the resident's care plan (alert alarm on at all times and not leaving the resident alone in the bathroom). The resident's care plan was not revised to address his concern of having a staff member present while he is in the bathroom. Also, the intervention to remind the resident to use the call light was not consistent with his cognitive level.	4 136		

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4 174	Continued From page 9	4 174		
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overal plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on record review and interview with staff members, the facility failed to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical needs that are identified in the comprehensive assessment for 3 of 14 sampled residents (Residents #77, #69, and #67) of the 26 residents reviewed. Findings include: 1) Record review done on /26/ 5 a :30 P.M. found Resident #67 has a physician s order for seroquel 25 mg., one tab PO QHS for dementia with behavioral disturbance and lorazepam 0.5 mg., give one tab prn QHS. Review of the Medication Administration Record was done with the Director of Nursing (DON) on /26/15 at 2:22 P.M. The DON confirmed the resident was given prn of lorazepam on 1/19/15. The DON also reported the resident receives routine lexapro for depression. Review of the resident's care plan for at risk for alteration in mood/behavior with diagnosis of dementia with behaviors and use of seroquel notes the following: resident has been refusing to shower on his sched led shower days, call daughter in law and inform of behavior and monitor for side effects of seroquel.	4 174	4 174-11-94.1-43(b) Interdisciplinary care process 1. By 2/12/15, for resident #67 the care plan was reviewed and revised by the SW, Dietitian and Nurses to include the following interventions: Non-pharmacological interventions for Seroquel/ Lexapro: When resident yells: Ensure resident's safety and come back in 5 minutes. Side effects related to Lexapro: weight gain, s eep diffic ties, lethargy Seroquel: drowsiness, s eepiness, chills, sweats, dystonia, akathesia, lips smacking, tongue movements. Refusal of showers. shower in early AM, S ffe showe daily /every shift if reside t refuses, com back and ask again, offer ath. For resident #69 the care plan was reviewed (2/13/15) and did in lud the ollowing interventions: Resident deve oped a coccygeal abrasion e to humidity to the coccyx on 9/9/14 with an o der of bacitracin ointment and to cover it with non-bordered foam d was o an air mattress. She had a fan was remin to turn and reposition hers . She had an ' eostomy and was on Magi Cup. Res dent was seen by a physician every esday. On 9/16/14 the dressing order was discontinued and changed to bacitracin ointment and to cover it wi	2/16/15

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4 174	Continued From page 10 Interview was done with the DON and MDS Coordinator on 1/28/14 at 10:45 A.M. Inquired what behavior is being monitored related to e use of seroquel, the response was for yelling. Further inquired what triggers the resident's behavior for yelling. The staff replied when staff or anyone visits and he is uncomfortable wi the person he will yell. The resident's daughter-in-law is contacted to visit with the resident to calm him down. Queried why the resident is refusing care, did the facility assess why the resident is refusing showers? Does the staff offer bed baths? The staff responded that since admission the resident doesn't want to be showered and a bed bath is probably offered but not sure whether he is agreeable. The staff members confirmed that the care plan for use of seroquel to address resident's behavior does not include non-pharmacological interventions. Inquired whether the resident has a care plan to include side effects related to the use of lexapro. The DON agreed to follow up. The DON did not provide further documentation of care plan to address the side effects related to the use of lexapro. 2) Cross reference to 4 136. The facility failed to update/revise R #69's care plan to ensure optimal skin care for prevention o further skin breakdown. The R #69 was admitt to the facility on 8/18/14 for aftercare following abdominal surgery. Her skin was intact aside from the abdominal incision. On 9/9/ 4 a Certified Nurses Aide, CNA, notified a ce sed Nurse, LN, about an abrasion on her coccyx. 9/9/14, an incident report (IR) was generated which noted the skin breakdown was due to humidity. The IR noted the resident was continent of bowel and b adder. The physician	4 174	Continued from page On 9/18/14 was placed n Ensure. n 9/23/14 the dressing order was discontinued and changed to bacitracin ointment and to cover it with ordere foam. On 9/ 0 14 the skin fractured and the diagnosis was changed to stag 2 pressure ulcer with a new dressing order of duodenum an change every 3 days Care plan was updated on 10/1/14. The resident was continent of bowel and bladde . All th above were care planned and do ume ted. For Resident #77 the staff was surprised to hear that he wanted to drink soda as he never requested that he wan so until questioned by the surv o on /27/ . He had not informed the staff therefore er was no hydration prefe ences sted o care plan. The dietitian assesses fo o and fluid preferences on admission and quarterly and was just assessed by her on 1/ 8/ 5. At this time the resident was assessed documented on the care plan by the dietitian and he did not state any fluid preferences. He did state that he wanted more "jook" which was increased to . e also refused to select his menu. Upon questioning the entire staff everyone denied the resident stated tha he wanted to soda. n 2/ 2/ 5 the resident's wife stated that she had eft the 2 bottles of water on the residen 's bedside and must have	

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4 174	Continued From page 11 was notified and he ordered dressing changes for the abrasion on 9/9/14. The resident already had an air mattress for prophylactic skin care. An air fan was placed in the room for increased comfort and to provide extra flow of air in the room. The incident report further indicated the resident was to be reminded to continuously turn and reposition herself in bed to prevent pressure ulcer and other skin issues. A review of the care plan titled "Potential/Actual Impaired Skin Integrity related to 1. Ileostomy, 2. Mid abdominal wound, and 3. (9/23/14) Coccyx", dated 9/2/14, noted the following approach: 0.5 x 0.2 cm excoriation to coccyx, clean with normal saline, apply Bacitracin ointment, cover with non-bordered foam every day. An approach was added on 9/23/14, "Coccygeal abrasion to coccyx. Clean with normal saline, apply Bacitracin ointment, cover with bordered foam every day. Another approach stated, "Timely incontinence care to keep skin clean and dry to ileostomy". The resident was assessed as continent of bowel and bladder but did require ostomy care. The R #69 was diagnosed with a Stage 2 pressure ulcer on 9/23/14 but it was not indicated on the care plan. She was discharged on 10/3/14 with a Stage 2 pressure ulcer. 3) The R #77 was admitted on 10/9/14 with diagnoses which included: Dementia NOS without behavioral disturbance; Chronic kidney disease Stage 3; Pneumonia. He got diagnosed with dehydration on 10/14/14 when a LN noted the resident was lethargic, drowsy, dry mouth, decreased urine output. The LN further indicated the resident's average meal intake over the previous 3 days was 25-50%. The physician was notified and ordered intravenous (IV) fluids. He	4 174	Continued from page 11. On 2/16/15 I spoke to the resident's daughter who stated that her mother brought the bottled water and drank some of it to take her pills. Both family members do not recall informing the staff of the preference to drink soda. In addition this resident was meeting his fluid goals. His average fluids for the entire month of January 2015 were 1600ml/ day with a fluid goal of 1400ml/ day. For resident #77 the Dietitian reviewed and revised the CP to include fluid methods and preferences of soda on 1/28/15. 2. On 2/5/15-2/13/15 all resident care plans were audited, reviewed and revised by the SW, Dietitian, and Nurses to ensure that the following is care planned: includes non-pharmacological interventions for residents on psychoactive medications; side effects interventions/monitoring related to medications use; interventions related to refusal of care; interventions to prevent pressure ulcers; and fluid preferences. 3. On 02/02/15 – 02/13/15 all Licensed Nurses, SW, Dietitian and CNAs (current, new and annually) were in-serviced on the requirements that care plans must be comprehensive and include non-pharmacological interventions for residents on psychoactive medications; side effects interventions/monitoring related to medications use; interventions related to refusal of care; interventions to prevent pressure ulcers; and fluid preferences.	02/13/15 02/13/15

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4 174	Continued From page 12 regained hydration and was taken off IV fluids. His care plan did not identify methods and preferences to meet his hydration needs. During observations on the afternoon of 1/27/15, an interview with R #77 revealed his desire to drink soda. He reported that he would love to drink a soda. Surveyor informed the resident that she would check with facility staff to see if he could get a soda. The R #77 discouraged the Surveyor from discussing it with the staff and stated, "Don't tell them. They won't do anything. You can do that for me. I don't want you to tell the staff because nothing will happen." At the resident's bedside were 2 small (6-8 oz.) bottles of water. One bottle was half filled while the other was unopened and full. On the afternoon of 1/27/15, the Licensed Nurse, LN #3, was notified of R #77's desire to drink soda. The LN #3 reported that the resident didn't have any dietary restrictions (ex. restricted sugar intake) aside from nectar-thickened liquids that would prevent him from having soda. She further stated that she would notify the oncoming nurse because her shift was ending. The LN #3 stated that she wasn't sure if soda could be thickened. She stated that she would notify the LN coming on the next shift and the Registered Dietician (RD) that the resident wanted soda and see what they could do. Interview of R #77 on the morning of 1/28/15 found him angry and agitated about not receiving a soda on 1/27/15. He stated that was why he didn't want the Surveyor to discuss it with the facility because nothing ever happened. On 1/28/15 at approximately 8:45 A.M., the LN #6 and the RD were notified. The LN #6 and RD stated that LN #3 did not notify the oncoming	4 174	Continued from page 12. All other staff (Dietitian, Food Service Manager) was in-serviced on 02/10/15. 4. The DON/designee will audit each month the care plans to ensure that it is comprehensive and includes interventions for non-pharmacological interventions for residents on psychoactive medications; side effects interventions/monitoring related to medications use; interventions related to refusal of care; interventions to prevent pressure ulcers; and fluid preferences and the results will be reported to the QA Committee each quarter. Completion date 02/16/15.	02/16/15

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4 174	Continued From page 13 nurse of the resident's request and therefore they also weren't aware. The RD immediately went in to see him. She stated that she wasn't aware of his preference for soda. A review of the care plan titled, "Resident is at nutrition/dehydration risk due to mechanically altered diet, variable oral intake, below ideal body weight, low BMI", dated 1/18/15, noted, "Provide fresh water and oral fluids preferred by the resident - distribute over 24 hours following daily fluid goal (1400 mL/day), (Nectar liquids)." The resident was experiencing poor oral intake, averaging 20% intake of meals over the previous 2 weeks (1/14/15 - 1/27/15). The care plan did not specify his fluid preferences. The staff (LN #6, LN #3, and RD) was unaware that he wanted to drink soda.	4 174		
4 194	11-94.1-46(k) Pharmaceutical services (k) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. This Statute is not met as evidenced by: Based on observation, staff interview, and review of medication administration guidelines, the facility failed to ensure that medications were stored and labeled with the resident's name and kept medications locked/observed at all times. Findings include: A medication administration was observed on 1/28/15 at 11:14 A.M. LN #8 released two pills from two separate blister packs into a small medicine cup for a resident. After releasing the	4 194	4 194-11-94.1-46(k) Pharmaceutical services 1. On 02/03/15 Licensed Nurse #8 was counseled/observed by the DON/ADON to not leave medications on top of the medication cart unlabeled and unattended by the DON/ADON. 2. All Lic. Nurses were in-serviced/observed by the DON/ADON on the policy that no medications are to be left unattended and unlabeled, such as on the medication cart completed by 02/13/15. 3. All new Lic. Nurses and annually will be in-serviced on the policy that no medications are to be left unattended and unlabeled, such as on the medication cart on 02/02/15 – 02/13/15. 4.The DON/designee will audit each month	02/03/15 02/13/15 02/13/15 02/16/15

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4 194	Continued From page 14 pills, she realized that she needed apple sauce for this resident. She did not label the medicine cup with the resident's name. She covered the medicine cup with 2 clear plastic drinking cups. Then, she left the medicine cup unattended on top of the medication cart. And, went to retrieve an apple sauce from the refrigerator nearby approximately twenty feet away from the medication cart. An interview was conducted with LN #8 a few minutes later regarding the facility's practice in leaving medications unattended. Staff stated that it was okay to leave medication for a short time as long as the medicine cup has the resident's name on it. But, she realized that she forgot to label the medicine cup with the resident's name. An interview was conducted with the DON on 1/28/15 at 1:30 P.M. Surveyor informed the DON regarding the medication administration observation of failing to label the medication cup with the resident's and maintaining the safety of the medication. The DON stated her expectation was for staff to label the medicine cup with the resident's name and either lock it in the medication cart or take the medicine cup with staff while enroute to the refrigerator to obtain the apple sauce. On 1/29/15 at 2:30 P.M., the "Nursing Care Center Pharmacy Policy and Procedure Manual - 2007 PharMerica Corp," 7.1 Medication Administration General Guidelines dated 12/12 Page 5 of 6 #17 was reviewed. The policy stated, "During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. The cart must be clearly visible to the personnel	4 194	Continued from page 14. that Lic. Nurses are not leaving medications unattended and unlabeled, such as on the medication cart and the results will be reported to the QA Committee each quarter. Completion date 02/16/15.	

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4 194	Continued From page 15 administering medications when unlocked."	4 194		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observation, interview with staff members and review of the facility's policy and procedures, the facility failed to maintain an infection control program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection. Finding include: 1) On 1/28/15 at 8:39 A.M. observed Restorative Nurse Aide #1 (RNA #1) wheeling a shower chair out of Room 116. The aide put the shower chair in Room 113 next to Resident #8's bedside. The aide reported that she would be providing a shower to Resident #8. RNA #1 and RNA #2 transferred the resident into the shower chair. RNA #1 wheeled the resident into the bathroom. Observation at 9:17 A.M. found the resident was placed in bed. RNA #1 was observed to grab towels and wipe the floor under the shower chair, then proceeded to wipe the seat of the chair with the same towels. The resident was transferred to her wheelchair and Certified Nurse Aide #1 (CNA #1) assisted RNA #1 to dress the resident. CNA #1 was observed to place slippers on the	4 203	4 203-11-94.1-53(a) Infection control 1. CNA #1 was counseled that that she is not to clean from dirty to clean such as place slippers on the resident's feet then without washing or sanitizing her hands proceed to brush a resident's hair on 02/14/15. RNA #1 was counseled on cleaning from dirty to clean and not to use the same towel to clean the floor then the shower chair on 02/13/15. An infection control policy was reviewed with the DON, RNA #1 that the PDI wipes are used to routinely clean the shower chairs before and after each use. The housekeepers will clean the shower chairs every day with disinfectant. The "orange top" containers with bleach will be used on equipment used by residents with C-difficile, suspected/actual on 02/09/15. All the shower chairs were power washed 2/12/15 and 2/13/15. LN #8 was counseled on the proper procedure to wash hands before and after each treatment on 02/03/15. LN #4 was counseled that she must sanitize her hands before administering medications on 02/04/15. 2. All Lic. Nurses and CNAs were in-serviced/ observed on not to clean from dirty to clean such as cleaning the floor then the shower chair and placing slippers on the resident's feet without washing or sanitizing	02/14/15 02/13/15

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4 203	Continued From page 16 resident's feet then without washing or sanitizing her hands proceeded to brush the resident's hair. CNA #2 placed the shower chair into the bathroom and commented that housekeeping should be called to clean the bathroom. The RNA reported that Resident #31 would be showered next. At 9:31 A.M. RNA #1 was observed in the bathroom, she took disposable cloths from a container with a purple lid and wiped down the seat of the shower chair. The container was labeled as PDI Super Sani Cloth Germicidal Disposable Wipe. There was an odor in the bathroom. The RNA reported that the seat of the shower chair needs to be wiped down as residents sometimes defecate during the shower. RNA #1 then wheeled the shower chair next to Resident #31's bed. On 1/28/15 at 2:14 P.M. CNA #3 was interviewed. Inquired whether she used the shower chair to shower a resident in Room 116. The CNA replied that she showered Resident #56. The CNA reported that she sanitizes the shower chair before and after the chair is used. Queried how the CNA sanitizes the shower chair. CNA #3 responded she will use the wipe cloths, ensuring she wipes down the seat, the back of chair, armrest and foot "thingy". Interview was done with the Director of Nursing (DON) on 1/28/15 at 2:16 P.M. Requested a copy of the facility's policy and procedure for sanitizing resident care equipment. The DON reported equipment should be rinsed or wiped with PDI wipe cloths. Inquired what areas should be rinsed/wiped. The DON responded the areas where the resident will have contact with the chair. Inquired whether the wipe cloths	4 203	Continued from page 16. hands and proceed to brush a resident's hair. Use of "orange tops" with bleach to clean equipment with residents with C-Difficile on 02/02/15 – 02/13/15. All Lic. Nurses were educated/observed on the requirement to wash hands before and after each treatment and to wash/sanitize hands before administering medications on 02/02/15 – 02/13/15. All housekeepers were trained on cleaning the shower chair daily with disinfectant, including the underneath. There will be a sign at the entrance of the door with a "C" to indicate that they need to use a bleach solution on 2/13/15. All shower chairs will be power washed every other month. 3. All new Lic. Nurses and CNAs and annually will be in-serviced/observed on cleaning equipment before and after each use, not to clean from dirty to clean such as cleaning the floor then the shower chair with same towel and placing slippers on the resident's feet without washing or sanitizing hands and proceed to brush a resident's hair. Use of "orange tops" with bleach to clean equipment with residents with C-Difficile on 02/13/15. Lic. Nurses are washing/sanitizing their hands after/before each treatment and before administering medications on 02/13/15. All new housekeepers and annually will be ins-serviced on the daily cleaning of the shower chair, including the underneath. Use of bleach solution for	02/13/15

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4 203	Continued From page 17 eradicates c-difficile? The DON replied that the cloths in the purple container does not kill c-difficile, the nursing staff will have to request bleach cloth and the plan is to purchase these cloths (orange top containers). The DON also reported that bleach solution should be used when resident has incident of bowel incontinence during a shower. Inquired how staff members know whether the equipment has been cleaned. At 2:51 P.M. the DON stated that the equipment should be cleaned before and after usage. Second observation was made at 2:50 P.M. with RNA #1 in Room 120. The RNA stated the wipes from the container with the purple top is used to sanitize and this is what is used if there is fecal matter on the equipment. Observation of the underside of the shower chair was made. At the back side of the seat there was brown spot along the joint of the seat and the frame. There was also some brown spots on the under side of the seat. The RNA said some of the spots were stains and she would take care of the rest and went into the bathroom and obtained wipe cloths from the container with the purple lid. The DON later reported that the staff in Environmental Services (EVS) informed her the use of the PDI wipes are used to sanitize the shower chair. The facility's policy and procedures for sanitizing shared resident care equipment was not provided prior to survey team's exit of the facility. The facility failed to ensure the spread of infections via resident care equipment as there was no evidence of procedures for cleaning the shower chair. Observation found staff members use PDI cloths to wipe the top of the seat of the shower chair. Interview with other staff members	4 203	Continued from page 17. with D-Difficile on 2/13/15. 4. The DON/designee will audit/observe each month that Lic. Nurses/CNAs are cleaning equipment before and after each use, not to clean from dirty to clean such as cleaning the floor then the shower chair with same towel and placing slippers on the resident's feet without washing or sanitizing hands and proceed to brush a resident's hair. The DON/ designee will audit/ observe each month that the staff use of "orange tops" with bleach to clean equipment with residents with C-Difficile, and Lic. Nurses are washing/ sanitize their hands after/before each treatment and before administering medications. The results will be reported to the QA Committee each quarter. Completion date 02/16/15.	02/16/15

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4 203	Continued From page 18 found sanitizing includes wiping the seat, back of chair, arm rest and legs of shower chair. Also, the PDI wipe cloths presently used for cleaning equipment does not address c-difficile. 2) An observation of left hip pressure ulcer dressing change was conducted on 1/28/15 at 9:46 A.M. First, LN #8 was observed to removed the old Opti-foam dressing from the pressure ulcer site, removed her gloves, and used the Sani-wipe to clean her hands. Then, she applied a new pair of disposable gloves to clean the wound site with normal saline. With the same gloves, she opened the Ziploc package from the medication cart that contained the Santyl ointment, opened the Q-tip and Opti-foam dressing. She applied the Santyl ointment with the Q-tip to the pressure ulcer site, then removed a pen from her uniform pocket and marked the Opti-foam dressing with the date and time. She applied the Opti-foam dressing to the pressure ulcer site, she then removed her gloves, did not wash her hands after the procedure, and returned the Santyl ointment and Sani-Wipes and Sani-cloth supplies to the treatment cart. An interview was conducted with the DON on 1/28/15 at 1:30 P.M. regarding pressure ulcer dressing changes. She stated staff should wash their hands before and after each time a treatment was done. The "Palolo Chinese Home Infection Control Policy and Procedure # 6.1 dated 1/1/12 Handwashing" was reviewed on 1/29/15 at 2:30 P.M. On page 2 of 2 section B: Other Aspects Of Hand Care And Protection #1 Glove use: "Gloves should be use as an adjunct to, not a substitute for, handwashing. Gloves should be use for hand-contaminating activities. Gloves should be	4 203		

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4 203	Continued From page 19 removed and hands washed when such activity is completed, when the integrity of the gloves is in doubt, and between residents." 3) On 1/28/2015 at 3:31 PM LN#4 was observed for medication administration. LN#4 released the medication for Resident #56 into a medicine cup then touched the mouse for the MAR and touched the computer keyboard. LN#4 then picked up the cup and spoon, went into the resident's room and fed the medication to Resident #56. An interview was conducted with LN#4 regarding hand sanitizing prior to administration of medications. RN#4 said she had forgotten to hand sanitize after touching the mouse and keyboard before administering the medication to Resident #56.	4 203		